Requests for vasectomy: counselling and consent

N M Harris MRCS S A V Holmes MS FRCS(Urol)

J R Soc Med 2001;**94**:510–511

Bilateral vasectomy is a safe and effective method of male sterilization. In the UK, around 23% of couples of reproductive age choose vasectomy as their method of contraception[1] and clinicians who care for and counsel these couples must be aware of their legal and moral responsibilities. Vasectomy is the urological operation that most commonly results in litigation. In counselling, several steps are necessary before valid consent can be obtained. The process should encompass the following:

- An assessment of the patient's contraceptive needs and discussion of alternative methods
- A general discussion of the surgical technique, tailored to the individual
- A frank and honest discussion of the risks and specific complications associated with vasectomy.

As with any medical intervention, only patients of sound mind and capable of understanding these issues are able to give valid consent[2,3].

This article focuses predominantly on the consent process and risks associated with vasectomy, then outlines some additional issues of interest to clinicians involved in management of vasectomy patients.

CONSENT

Dissatisfaction with the result of vasectomy usually arises from incomplete or inadequate discussion of the associated risks and their incidence rates. First, the clinician must make clear that the procedure is permanent and irreversible. It is not appropriate to discuss the option of vasovasostomy (vasectomy reversal) should the patient subsequently desire a return of his fertility. This procedure has a poor success rate and is not routinely available in the National Health Service.

Secondly, although vasectomy is an effective and reliable procedure, it will be unsuccessful in perhaps 1 in 1000 cases and these patients will not become azoospermic after surgery[4]. The reasons are technical failure, very early recanalization of the vas deferens or presence of an accessory vas unrecognized at the time of surgery. Of greater consequence (though less common at about 1 in 2000 cases[5]) is late recanalization, which can manifest as return of fertility and subsequent unplanned pregnancy. There have also been cases of DNA-confirmed paternity despite documented azoospermia before and after conception[6]. This can have devastating social and financial consequences. Patients must understand that vasectomy does not offer a guarantee of permanent sterility.

Thirdly, up to 6% of patients experience chronic testicular discomfort after vasectomy[4]. The various causes of this pain include congestive epididymitis, sperm granuloma and infective epididymo-orchitis. The discomfort may be no more than a low-grade chronic ache that causes little disability and requires only symptomatic treatment. However, a proportion of patients will be sufficiently debilitated to seek epididymectomy or even orchidectomy. Furthermore, for a very small number of patients even this radical surgery will not provide relief from their scrotal discomfort.

Fourthly, the patient must understand that post-vasectomy semen analysis (PVSA) is mandatory, to confirm azoospermia. Not until azoospermia has been demonstrated can alternative methods of contraception be safely discarded.

FOLLOW-UP

Post-vasectomy sterility is confirmed by semen analysis, but the disappearance of spermatozoa from the ejaculate can be slow. Age and frequency of ejaculation probably influence the time to achieve azoospermia. Some patients continue to have small numbers of non-motile spermatozoa in their ejaculate for months or years after vasectomy[7]; no pregnancies, however, have been reported in partners of men with this sperm picture and many urologists advise that alternative contraception can be safely discontinued.

There remains controversy as to the number and timing of PVSA. Bradshaw *et al.*[8] suggest that only one PVSA may be necessary, if performed at 4 months; however, standard practice is to require two consecutive azoospermic samples, usually at 3 and 4 months, to confirm operative success. The logistics of PVSA should also be agreed upon. In most cases the PVSA will be organized through the patient's general practitioner, but precise arrangements should be clarified with the patient during the consent process.

Solent Department of Urology, St Mary's Hospital, Portsmouth, PO3 6AD, UK
Correspondence to: Mr Neil Harris

Re-exploration and repeat vasectomy

There are no firm guidelines as to when vasectomy should be considered to have failed when PVSA continues to demonstrate motile spermatozoa. Spermatozoa can re-appear temporarily in patients who were initially azoospermic, but this in itself does not warrant re-exploration and repeat vasectomy. A reasonable policy is to offer repeat vasectomy to patients with persistent motile sperm on consecutive semen analysis for 6 months or more after surgery.

OTHER ISSUES

Prostate and testicular cancer risk

A systematic review has allayed concerns that vasectomy leads to an increase in the subsequent risk of prostate cancer[9]. Similarly, large cohort studies have provided reassuring information with regard to risk of testicular cancer in men who have undergone vasectomy[10–12]. These cancers may well come into the discussion at initial consultations or subsequently, but there is no obligation to mention them in counselling for vasectomy.

Compensation claims

As in other cases of medical litigation, a failure to communicate effectively with the patient is a common factor. Failure to inform the patient of the risks outlined above can leave a clinician open to charges of *battery* if a valid consent is not obtained, or *negligence* if a doctor does not exercise the duty of care by adequately communicating information about the procedure.

Consent by partner

It is not a legal requirement to involve both partners in the decision-making and consent process. There is a widespread misconception that a wife must consent to her husband undergoing vasectomy. If, against a man's wishes, his wife is informed of and asked to consent to her husband's vasectomy, this can be regarded as a breach of medical confidentiality and an infringement of an individual's right to self-determination (i.e. autonomy).

Nevertheless, it is good practice to involve both partners if the male agrees.

CONCLUSION

Vasectomy is a safe and effective method of long-term contraception. However, as with all surgical procedures, full and informed consent needs to be obtained from the patient beforehand. The Department of Health has published guidelines on obtaining valid consent for operation or treatment[3] which highlights the following areas: does the patient have the capacity to consent; is the consent given voluntarily; has the patient received sufficient information; and is the consent obtained by a suitably trained and qualified person? For minimum risk of subsequent litigation these points of consent are coupled with scrupulous surgical technique and rigorous follow-up.

REFERENCES

1 Roberts H. Good practice in sterilisation. *BMJ* 2000;**320**:662–3

2 Jones MA. *Medical Negligence*. London: Sweet & Maxwell, 1991

3 Department of Health. *Reference Guide to Consent for Examination or Treatment*. London: DoH, 2001

4 Schwingl PJ, Guess HA. Safety and effectiveness of sterilisation. *Fertil Steril* 2000;**73**:923–36

5 Halder N, Cranston D, Turner E, MacKenzie I, Guillebaud J. How reliable is vasectomy—long term follow-up of vasectomised men. *Lancet* 2000;**356**:43–4

6 Smith JC, Cranston D, O'Brien T, Guillebaud J, Hindmarsh J, Turner AG. Fatherhood without apparent spermatozoa after vasectomy. *Lancet* 1994;**344**:30

7 O'Brien TS, Cranston D, Guillebaud J, *et al*. Temporary reappearance of sperm 12 months after vasectomy clearance. *Br J Urol* 1995;**76**: 371–2

8 Bradshaw HD, Rosario DJ, James MJ, Boucher NR. Review of current practice to establish success after vasectomy. *Br J Surg* 2001;**88**: 290–3

9 Bemal-Delgado E, Latour-Perez J, Pradas-Arnal F, Gomez-Lopez L. The association between vasectomy and prostate cancer: a systematic review of the literature. *Fertil Steril* 1998;**70**:191–200

10 Moller H, Knudsen LB, Lynge E. Risk of testicular cancer after vasectomy: cohort study of over 73000 men. *BMJ* 1994;**309**295–9

11 Giovannuci E, Tosteson TD, Speizer FE, Vessey MP, Golditz GA. A long term study of mortality in men who have undergone vasectomy. *N Engl J Med* 1992;**326**:1392–8

12 Massey FJ, Bernstein GS, O'Fallon WM, *et al*. Vasectomy and health. Results from large cohort study. *JAMA* 1984;**252**:1023–9